

C.P. v. Blue Cross Blue Shield of Illinois
USDC (W.D. Wash.), No. 3:20-cv-06145-RJB

CONFIDENTIAL EXHIBIT

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Exhibit 6

The Honorable Robert J. Bryan

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA**

C. P., by and through his parents, Patricia
Pritchard and Nolle Pritchard; and PATRICIA
PRITCHARD,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

No. 3:20-cv-06145-RJB

EXPERT REPORT OF RANDI C. ETTNER, PH.D.

I, Randi C. Ettner, Ph.D., hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am a licensed clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria. I received my doctorate in psychology from

1 Northwestern University in 1979. I was the chief psychologist at the Chicago Gender Center
2 from 2005 to 2016, when it moved to the Weiss Memorial Hospital. Since that time, I have been
3 a consultant to the Center for Gender Confirmation Surgery at Weiss Memorial Hospital and a
4 member of the Medical Staff. The center specializes in the treatment of individuals with gender
5 dysphoria. I have been involved in the treatment of patients with gender dysphoria since 1977,
6 when I was an intern at Cook County Hospital in Chicago.

7 4. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of
8 Psychological Specialties, and a Fellow and Diplomate in Trauma/Posttraumatic Stress Disorder
9 (PTSD).
10

11 5. During the course of my career, I have evaluated and/or treated over 3,000
12 individuals with gender dysphoria and mental health issues related to gender variance.

13 6. I have published four books related to the treatment of individuals with gender
14 dysphoria, including the medical text entitled *Principles of Transgender Medicine and Surgery*
15 (Ettner, Monstrey & Eyler, 2007) and the second edition (Ettner, Monstrey & Coleman, 2016). I
16 also have authored numerous articles in peer-reviewed journals regarding the provision of care to
17 this population. I serve as a member of the editorial boards for the *International Journal of*
18 *Transgenderism and Transgender Health*.
19

20 7. I am the immediate past Secretary of the World Professional Association for
21 Transgender Health (“WPATH”) (formerly the Harry Benjamin Gender Dysphoria Association),
22 as well as a member of the Board of Directors for 12 years. I am an author of the *WPATH*
23 *Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming*
24 *People* (7th version), published in 2011. The WPATH promulgated *Standards of Care*
25 (“*Standards of Care*”) are the internationally recognized guidelines for the treatment of persons
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1 with gender dysphoria and serve to inform medical treatment in the United States and throughout
2 the world.

3 8. I have lectured throughout North America, South America, Europe, and Asia on
4 topics related to gender dysphoria, and on numerous occasions I have presented grand rounds on
5 gender dysphoria at medical hospitals.

6 9. I am the honoree of the externally-funded *Randi and Fred Ettner Fellowship in*
7 *Transgender Health* at the University of Minnesota. I have been an invited guest at the National
8 Institute of Health to participate in developing a strategic research plan to advance the health of
9 sexual and gender minorities, and in November 2017 was invited to address the Director of the
10 Office of Civil Rights of the United States Department of Health and Human Services regarding
11 the medical treatment of gender dysphoria. I received a commendation from the United States
12 House of Representatives on February 5, 2019 recognizing my work for WPATH and on the
13 treatment of gender dysphoria in Illinois.

14 10. I have treated hundreds of PTSD patients who experience the long-term
15 psychological effects of trauma. As a forensic psychologist, I have been retained as an expert and
16 testified in numerous cases about the harm that befalls victims of criminal victimization, natural
17 catastrophes, and exposure to extremely stressful events.

18 11. I have been retained as an expert regarding gender dysphoria and its treatment in
19 multiple court cases in both state and federal courts, as well as administrative proceedings, and
20 have repeatedly qualified as an expert. I have also been a consultant to policy makers regarding
21 appropriate care for transgender inmates and for the Centers for Medicare and Medicaid in the
22 state of Illinois. I have also served as a consultant to multiple school districts in the state of
23 Wisconsin as well as the Chicago public school system on issues related to gender identity.
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1 12. The information provided regarding my professional background, experiences,
2 publications, and presentations are detailed in my curriculum vitae. A true and correct copy of my
3 most up-to-date curriculum vitae is attached as **Exhibit A**.

4 **B. Compensation**

5 13. I am being compensated for my work on this matter at a rate of \$375.00 per hour
6 for preparation of declarations and expert reports. I will be compensated \$500.00 per hour for any
7 pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. I will
8 receive a flat fee of \$2,500.00 for any travel time to attend deposition or trial, and will be
9 reimbursed for reasonable out-of-pocket travel expenses incurred for the purpose of providing
10 expert testimony in this matter. My compensation does not depend on the outcome of this
11 litigation, the opinions I express, or the testimony I may provide.

12 **C. Previous Testimony**

13 14. Over the past four years, I have given expert testimony at trial or by deposition
14 in the following cases: *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C. 2021); *Iglesias v.*
15 *Connor*, No. 19-cv-0415-RJN (S.D. Ill. 2021); *Monroe v. Jeffreys*, No. 18-15-156-NJR (S.D. Ill.
16 2021); *Singer v. Univ. of Tennessee Health Sciences Ctr.*, No. 2:19-cv-02431-JPM-cgc (W.D.
17 Tenn. 2021); *Morrow v. Tyson Fresh Meats, Inc.*, No. 6:20-cv-02033 (N.D. Iowa 2021); *Claire*
18 *v. Fla. Dep't of Mgmt. Servs.*, No. 4:20-cv-00020-MW-MAF (N.D. Fla. 2020); *Williams v.*
19 *Allegheny Cty.*, No. 2:17-cv-01556-MJH (W.D. Pa. 2020); *Gore v. Lee*, No. 3:19-CV-00328
20 (M.D. Tenn. 2020); *Eller v. Prince George's Cnty. Public Sch.*, No. 8:18-cv-03649-TDC (D.
21 Md. 2020); *Monroe v. Baldwin*, No. 18-CV-00156-NJR-MAB (S.D. Ill. 2020); *Ray v. Acton*,
22 No. 2:18-cv-00272 (S.D. Ohio 2019); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019);
23 *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW (D. Idaho 2018).
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II. BASES FOR OPINIONS

15. In preparing this report, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. A true and accurate copy of my curriculum vitae is attached hereto as **Exhibit A**. It documents my education, training, research, and years of experience in this field and includes a list of my publications.

16. I have also reviewed the materials listed in the bibliography attached hereto as **Exhibit B**. The sources cited therein are authoritative, scientific peer-reviewed publications. I generally rely on these materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this report.

17. I also rely upon my interviews of C.P. and his parents on March 19, 2022, and C.P.'s mental health and medical records.

18. Additionally, I have reviewed the Amended Class Action Complaint (ECF No. 38) and the court's Order Denying Defendant's Motion to Dismiss (ECF No. 23) in this case.

19. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

III. EXPERT OPINIONS

A. Sex and Gender Identity

20. At birth, infants are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate, and their birth-assigned sex matches that person's actual sex. However, for transgender people, the sex assigned at birth does not align with the individual's genuine, experienced sex, resulting in the clinical distress that characterizes the condition of gender dysphoria.

21. Research has identified that determination of sex is far more complex than what is seen as part of a genital exam. Instead, a number of factors go into the determination of a person's sex. Among the factors that comprise a person's sex are their chromosomal composition (detectable through karyotyping); gonads and internal reproductive organs (detectable by ultrasound, and occasionally by a physical pelvic exam); external genitalia (which are visible at birth); fetal hormones (production of sex hormones by the fetus or exogenous exposure of sex hormones to the developing fetus); pubertal hormones (the change in hormonal milieu that results in the development of secondary sexual characteristics, such as facial hair and deep voice for those assigned male at birth, or breasts and menstrual cycles for those assigned female at birth); sexual differentiations in brain development and structure (detectable by functional magnetic resonance imaging studies and autopsy); and gender identity.

22. Gender identity is a person's inner sense of belonging to a particular sex, such as male or female. It is a deeply felt and core component of human identity and is a well-established concept in science and medicine. Every person has a gender identity. Like non-transgender people (also known as cisgender people), transgender people do not simply have a "preference" to act or behave consistently with each one's gender identity.

1 23. The only difference between transgender people and cisgender people is that the
2 latter have gender identities that are consistent with their birth-assigned sex whereas the former
3 do not. A transgender man cannot simply turn off his gender identity like a switch, any more than
4 anyone else could.

5 24. In other words, transgender men are men and transgender women are women.

6 25. A growing assemblage of research documents that gender identity is immutable
7 and biologically based. Efforts to change an individual's gender identity are therefore both futile
8 and unethical.

9 26. The evidence demonstrating that gender identity cannot be altered, either for
10 transgender or for non-transgender individuals, further underscores the innate and immutable
11 nature of gender identity. Past attempts to "cure" transgender individuals by means of
12 psychotherapy, aversion treatments or electroshock therapy, in order to change their gender
13 identity to match their birth-assigned sex, have proven ineffective and caused extreme
14 psychological damage. All major associations of medical and mental health providers, such as
15 the American Medical Association, the American Psychiatric Association, the American
16 Psychological Association, and WPATH's *Standards of Care*, consider such efforts unethical.

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19 **B. Gender Dysphoria and Its Treatment**

20 27. Gender dysphoria is the clinically significant distress or impairment of functioning
21 that can result from the incongruence between a person's gender identity and the sex assigned to
22 them at birth. Gender dysphoria is a serious medical condition associated with severe and
23 unremitting distress that results from the incongruity between various aspects of one's sex. It is
24 codified in the *International Classification of Diseases* (11th revision: World Health
25 Organization), the diagnostic and coding compendia for mental health and medical professionals,
26

1 and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental*
2 *Disorders*, Fifth Edition (DSM-5). People diagnosed with gender dysphoria have an intense and
3 persistent discomfort with their assigned sex.

4 28. In 1980, the American Psychiatric Association introduced the diagnostic term
5 gender identity disorder (GID) in the third edition of the Diagnostic and Statistical Manual of
6 Mental Disorders (DSM-III). The diagnosis of GID was maintained in a revised version of DSM,
7 known as DSM-III-R (1987), as well as in the DSM-IV, which was issued in 1994. The gender
8 identity disorder diagnosis presupposed that a person's identity was disordered, and was therefore
9 a permanent condition.
10

11 29. In 2013, the American Psychiatric Association removed the GID diagnosis and
12 replaced it with a fundamentally different diagnosis, gender dysphoria. The change was not merely
13 a name change but was based on the evolving scientific understanding that gender incongruence
14 is not a mental illness, but rather a serious, treatable medical condition that creates significant
15 distress. This new diagnostic term, gender dysphoria, is an acknowledgment that gender
16 incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's identity
17 disordered. Rather, the diagnosis is based on the distress or dysphoria that some transgender people
18 experience as a result of the incongruence between the sex assigned at birth and gender identity,
19 and the social problems that ensue. The critical element of the gender dysphoria diagnosis is the
20 presence of symptoms that meet the threshold of clinical impairment. The American Psychiatric
21 Association changed the name and diagnostic criteria to be "more descriptive than the previous
22 DSM-IV term gender identity disorder and focus[] on dysphoria as the clinical problem, not
23 identity per se." DSM-5 at 451.
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1 30. “Gender Dysphoria” is the name of the diagnosis, and “gender dysphoria” is also
2 the psychiatric term for the severe and unremitting distress that the condition gives rise to.

3 31. The diagnostic criteria for gender dysphoria in Adolescents and Adults are as
4 follows:

5 a. A marked incongruence between one’s experienced/expressed gender and assigned
6 gender, of at least six months’ duration, as manifested by at least two of the
7 following:

8 i. A marked incongruence between one’s experienced/expressed gender and
9 primary and/or secondary sex characteristics (or in young adolescents, the
10 anticipated secondary sex characteristics).

11 ii. A strong desire to be rid of one’s primary and/or secondary sex
12 characteristics because of a marked incongruence with one’s
13 experienced/expressed gender (or in young adolescents, a desire to prevent
14 the development of the anticipated sex characteristics).

15 iii. A strong desire for the primary and/or secondary sex characteristics of the
16 other gender.

17 iv. A strong desire to be of the other gender (or some alternative gender
18 different from one’s assigned gender).

19 v. A strong desire to be treated as the other gender (or some alternative gender
20 different from one’s assigned gender).

21 vi. A strong conviction that one has the typical feelings and reactions of the
22 other gender (or some alternative gender different from one’s assigned
23 gender).

- 1 b. The condition is associated with clinically significant distress or impairment in
2 social, occupational or other important areas of functioning.

3 32. Once a diagnosis of gender dysphoria is established, individualized treatment
4 should be initiated. Without treatment, individuals with gender dysphoria experience anxiety,
5 depression, suicidality, and other attendant mental health issues and are often unable to adequately
6 function in occupational, social, or other areas of life.

7 33. The medically accepted standards of care for treatment of gender dysphoria are set
8 forth in the *WPATH Standards of Care* (7th version, 2011), first published in 1979. The WPATH-
9 promulgated *Standards of Care* are the internationally recognized guidelines for the treatment of
10 persons with gender dysphoria and inform medical treatment throughout the world.
11

12 34. The American Medical Association, the Endocrine Society, the American
13 Psychological Association, the American Psychiatric Association, the World Health Organization,
14 the American Academy of Family Physicians, the National Commission of Correctional Health
15 Care, the American Public Health Association, the National Association of Social Workers, the
16 American College of Obstetrics and Gynecology, the American Society of Plastic Surgeons, and
17 The American Society of Gender Surgeons all endorse protocols in accordance with the WPATH
18 standards. (See, e.g., AMA, 2019; American Psychological Association, 2015; Drescher, et al.,
19 2018 (American Psychiatric Association); Hembree, et al., 2017 (Endocrine Society); ACOG,
20 2021; NCCHC, 2009).
21

22 35. The *Standards of Care* identify the following treatment protocols for treating
23 individuals with gender dysphoria, which should be tailored to the patient's individual medical
24 needs:
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- a. Changes in gender expression and role, also known as social transition (which involves living in the gender role consistent with one's gender identity);
- b. For transgender youth, treatment options include pubertal suppression therapy.
- c. Hormone therapy to feminize or masculinize the body in order to reduce the distress caused by the discordance between one's gender identity and sex assigned at birth;
- d. Surgery to change primary and/or secondary sex characteristics; and
- e. Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; and promoting resilience.

36. The ability to live in a manner consistent with one's gender identity is critical to a person's health and well-being and is a key aspect in the treatment of gender dysphoria. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition. The steps that each transgender person takes to transition are not identical.

37. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. In other words, whether any particular treatment is medically necessary or even appropriate depends on the medical needs of the individual.

38. **Psychotherapy:** Psychotherapy can provide support and help with many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for

1 medical intervention when medical interventions are required, nor is it a precondition for medically
2 indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing
3 psychoeducation about living with chronic illness and nutritional information, but counseling does
4 not obviate the need for insulin.

5 39. **Puberty Blockers: Puberty** Puberty blocking medication, which involves the
6 administration of gonadotrophin-releasing hormone analogues (GnRH), comprises methods of
7 temporarily suppressing endogenous puberty to alleviate gender dysphoria and give the patient
8 more time to work with their mental health and medical providers to assess treatment needs. These
9 blockers are reversible medications and once stopped, a patient immediately returns to the stage
10 of pubertal development that had begun when the treatment was initiated.
11

12 40. Puberty suppression also has the benefit of potentially rendering obsolete some
13 gender-affirming surgeries down the line, such as male chest reconstruction, tracheal shave, facial
14 feminization, and vocal cord alteration, which otherwise would be required to correct the initial
15 “incorrect” puberty.
16

17 41. Puberty suppression has been used safely for decades in children with other
18 medical conditions. (de Vries, et al., 2014). Both the Endocrine Society and the WPATH’s
19 Standards of Care recommend initiation of puberty suppression at the earliest stages of puberty
20 (usually, Tanner 2), in order to avoid the stress and trauma associated with developing secondary
21 sex characteristics of the natal sex.

22 42. **Hormone Therapy:** For individuals with persistent, well-documented gender
23 dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress
24 of the condition. Cross sex hormone administration is a well-established and effective treatment
25 modality for gender dysphoria. The American Medical Association, the Endocrine Society, the
26

1 American Psychiatric Association, and the American Psychological Association all concur that
2 hormone therapy, provided in accordance with the WPATH *Standards of Care*, is the medically
3 necessary, evidence-based, best practice care for most patients with gender dysphoria.

4 43. The goals of hormone therapy are (1) to significantly reduce hormone production
5 associated with the person's birth sex, causing the unwanted secondary sex characteristics to
6 recede, and (2) to replace the natal, circulating sex hormones with either feminizing or
7 masculinizing hormones, using the principles of hormone replacement treatment developed for
8 hypogonadal patients (*i.e.*, those born with insufficient sex steroid hormones).
9

10 44. The therapeutic effects of hormone therapy are twofold. First, with endocrine
11 treatment, the patient acquires secondary sex characteristics congruent with their gender identity.
12 For transgender women, this means, *inter alia*, breast development, redistribution of body fat,
13 cessation of male pattern baldness, and reduction of body hair. For transgender men, this means,
14 *inter alia*, the voice deepens, growth of facial and body hair, redistribution of body fat, and overall
15 increase in muscle mass. Second, hormones act directly on the brain, via receptor sites, attenuating
16 the dysphoria and attendant psychiatric symptoms, and promoting a sense of well-being.
17

18 45. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone
19 therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention.

20 46. For many transgender women patients, hormones alone will not provide sufficient
21 breast development to approximate the female torso. For these patients, breast augmentation has
22 a dramatic, irreplaceable, and permanent effect on reducing gender dysphoria, and thus
23 unquestionable therapeutic results. Conversely, for many transgender men, hormones alone do
24 not reduce breast tissue and they therefore require surgical intervention, such as a mastectomy and
25 male chest contouring, to eliminate this most obvious typically female sex characteristic.
26

1 47. For transgender women, genital confirmation surgery has two therapeutic
2 purposes. First, removal of the testicles eliminates the major source of testosterone in the body.
3 Second, the patient attains body congruence resulting from the normal appearing and functioning
4 female uro-genital structures. Both outcomes are crucial in attenuating or eliminating gender
5 dysphoria. Additionally, breast augmentation procedures play the critical role in treatment
6 mentioned in the paragraph immediately above.

7 48. For many transgender men, gender confirmation surgery in the form of a
8 hysterectomy—the removal of female reproductive organs, such as the uterus, ovaries, fallopian
9 tubes and cervix—is a medically necessary procedure for the treatment of gender dysphoria. A
10 hysterectomy confers three therapeutic benefits: First, it eliminates a source of estrogen and
11 preexisting conditions of tumors, cysts, fibroids or endometriosis. Second, it removes the increased
12 risk of ovarian cancer (thought to originate in the fallopian tubes) and other typically female
13 cancers associated with atrophied organs. Finally, a hysterectomy eliminates the need for routine
14 gynecological exams and significantly attenuates gender dysphoria.
15

16 **C. Gender-Affirming Medical and Surgical Treatment Are Safe and Effective.**
17

18 49. There is a large and growing body of evidence that demonstrates that the
19 provision of gender affirming medical and surgical treatment to treat gender dysphoria are both
20 safe and effective.

21 50. Peer-reviewed cross-sectional and longitudinal studies have found that the use of
22 puberty blockers is associated with a range of improved mental health outcomes for transgender
23 adolescents, including statistically significant improvements in internalizing psychopathology
24 (*e.g.*, anxiety and depression), externalizing psychopathology (*e.g.*, disruptive behaviors), global
25 functioning, and suicidality. (*e.g.*, Achilles, et al., 2020; Turban, et al., 2020; van der Miesen, et
26

1 al., 2020; de Vries, et al., 2014; de Vries, et al., 2011). For example, a study by van der Miesen et
2 al., which compared 272 adolescents who had not yet received pubertal suppression with 178
3 adolescents who had been treated with pubertal suppression, found that those who had received
4 pubertal suppression had statistically significant lower “internalizing psychopathology” scores (a
5 measure of anxiety and depression). And de Vries et al.’s longitudinal study similarly found
6 statistically significant improvements in symptoms of depression and general functioning
7 following pubertal suppression for adolescents with gender dysphoria.
8

9 51. Decades of scientific research have validated the many benefits of hormonal
10 therapy for gender dysphoric patients. Peer-reviewed research studies have likewise found
11 improved mental health outcomes following gender-affirming hormone treatment (*e.g.*, estrogen
12 or testosterone) for individuals with gender dysphoria, including adolescents. These include
13 statistically significant improvements in internalizing psychopathology (*e.g.*, anxiety and
14 depression), general well-being, and suicidality. (*e.g.*, Grannis, et al., 2021; Meyer, et al., 2020;
15 Achille, et al., 2020; Allen, et al., 2019; Heylens, et al., 2014; Colizzi, et al., 2014; Colizzi, et al.,
16 2013; Gomez-Gil, et al., 2012).
17

18 52. As early as 1980, researchers demonstrated that gender dysphoric patients living
19 without hormonal treatment showed greater psychopathology than patients who received
20 hormonal treatment; and greater adjustment was associated with longer periods of treatment
21 (Leavitt, et al.). Untreated patients exhibit much higher levels of depression, anxiety, and social
22 distress. (Rametti, et al., 2011; see also Colizzi, et al., 2014; Gorin-Lazard, et al., 2011.).
23 Hormonal treatment improves overall health in gender dysphoric patients and is associated with
24 a better quality of life (Gomez-Gil, et al., 2012; Colizzi, et al., 2013; Gorin-Lazard, et al., 2011).
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1 53. The American Medical Association, the Endocrine Society, the American
2 Psychiatric Association and the American Psychological Association also all agree that hormone
3 therapy is medically necessary treatment for many individuals with gender dysphoria. (See
4 Endocrine Society, 2017; American Medical Association, 2008; American Psychological
5 Association, 2015; American Psychiatric Association, 2012; American Psychiatric Association,
6 2009).

7 54. Decades of methodologically sound and rigorous scientific research have also
8 demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender
9 dysphoria and, indeed, for many, it is the only effective treatment. The American Medical
10 Association, the Endocrine Society, the American College of Obstetricians and Gynecologists, the
11 American Psychological Association, and the American Psychiatric Association all endorse
12 surgical therapy, in accordance with the WPATH *Standards of Care*, as medically necessary
13 treatment for individuals with severe gender dysphoria.
14

15 55. Surgeries are considered “effective” from a medical perspective, if they “have a
16 therapeutic effect” (Monstrey, et al., 2007). More than three decades of research confirms that
17 gender confirmation surgery is therapeutic and therefore an effective treatment for gender
18 dysphoria. (e.g., Almazan, et al., 2021; Murad, et al., 2010; Smith, et al., 2005; Pfafflin & Junge,
19 1998). Indeed, for many patients with severe gender dysphoria, gender confirmation surgery is
20 the only effective treatment.
21

22 56. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies, from
23 12 countries, spanning 30 years. They concluded that “reassignment procedures were effective in
24 relieving gender dysphoria. There were few negative consequences and all aspects of the
25 reassignment process contributed to overwhelmingly positive outcomes” (Pfafflin & Junge, 1998).
26

1 57. Numerous subsequent studies confirm this conclusion. Researchers reporting on a
2 large-scale prospective study of 325 individuals in the Netherlands concluded that after surgery
3 there was “a virtual absence of gender dysphoria” in the cohort and “results substantiate previous
4 conclusions that sex reassignment is effective” (Smith, et al., 2005). Indeed, the authors of the
5 study concluded that the surgery “appeared therapeutic and beneficial” across a wide spectrum of
6 factors and “[t]he main symptom for which the patients had requested treatment, gender dysphoria,
7 had decreased to such a degree that it had disappeared.” Similarly, a recent systematic review that
8 included data from 1,052 transmasculine patients who obtained chest surgery found that pooled
9 overall postoperative satisfaction was 92%. (Bustos, et al., 2021).
10

11 58. As a general matter, patient satisfaction is a relevant measure of effective treatment.
12 Achieving functional and normal physical appearance consistent with gender identity alleviates
13 the suffering of gender dysphoria and enables the patient to function in everyday life. Studies have
14 shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender
15 confirmation surgery improves virtually every facet of a patient’s life. This includes satisfaction
16 with interpersonal relationships and improved social functioning (Rehman, et al., 1999; Johansson,
17 et al., 2010; Hepp, et al.; 2002; Ainsworth & Spiegel, 2010; Smith, et al., 2005); improvement in
18 self-image and satisfaction with body and physical appearance (Lawrence, 2003; Smith, et al.,
19 2005; Weyers, et al., 2009); and greater acceptance and integration into the family (Lobato, et al.,
20 2006).
21

22 59. Studies have also shown that surgery improves patients’ abilities to initiate and
23 maintain intimate relationships (Lobato, et al., 2006; Lawrence, 2005; Lawrence, 2006; Imbimbo,
24 et al., 2009; Klein & Gorzalka, 2009; Jarolim, et al., 2009; Smith, et al., 2005; Rehman, et al.,
25 1999; DeCuypere, et al., 2005).
26

1 60. With regards to transgender adolescents, peer-reviewed research has also shown
2 improvements in mental health following gender-affirming chest surgery for transgender males
3 with gender dysphoria where medically indicated. (Mehringer, et al., 2021; Olson-Kennedy, et al.,
4 2018).

5 61. The research and studies supporting the medical necessity, safety, and
6 effectiveness of gender affirming medical and surgical care for the treatment of gender dysphoria
7 is the same type of evidence-based data that the medical community routinely relies upon when
8 treating other medical conditions.

9 62. Given the decades of extensive experience and research supporting the
10 effectiveness of gender affirming medical and surgical treatment, it is clear that this care is
11 medically necessary for the treatment of gender dysphoria, and not experimental or cosmetic.

12 63. Because of the overwhelming scientific evidence that gender affirming medical
13 care, including gender confirmation surgery, is medically necessary for the treatment of gender
14 dysphoria in some patients, many of the leading medical and professional organizations have
15 stated their opposition to exclusions of insurance coverage for that care, including the American
16 Medical Association, American Academy of Family Physicians, American College of
17 Obstetricians and Gynecologists, American Psychiatric Association, and WPATH. (See American
18 Medical Association and GLMA, 2019; WPATH, 2016; American Psychiatric Association, 2012;
19 American Academy of Family Physicians, 2012; American College of Obstetricians and
20 Gynecologists, 2011; American Medical Association, 2008; American Psychological Association,
21 2008.).

22 64. Finally, insuring transition-related care is affordable and cost-effective for a
23 number of reasons. First, only a small percentage of the population is transgender. While there are
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1 a range of estimates, most studies indicate that transgender people comprise less than 1 percent
2 (ranging from approximately 0.1 to 0.6 percent) of the United States population. Second, even
3 among this small population, not every person will require various surgical procedures because
4 individual medical needs vary, and some may be precluded from surgery based on age or other
5 health conditions. While absorbing the cost of this care can be challenging on an individual's
6 personal budget, researchers affiliated with the Johns Hopkins Bloomberg School of Public
7 Health, and the RAND Corporation, have demonstrated that the cost of insuring surgical care
8 through a group health plan is negligible at most. (Padula et al., 2015; RAND Corp., 2016).
9 Moreover, offering access to medically necessary transition-related care is far more cost-effective
10 than denying coverage and having to treat the resulting consequences, which can include
11 depression, anxiety, suicidality, and other conditions.
12

13 **D. Harms Resulting from the Denial of Care.**

14 65. The overarching goal of treatment for gender dysphoria is to eliminate clinically
15 significant distress by aligning an individual patient's body and presentation with their internal
16 sense of self, thereby consolidating identity. Developing and integrating a positive sense of self-
17 identity formation is a fundamental undertaking for all human beings. Denial of medically
18 indicated care to transgender people signals that such people are "inferior" or "unworthy," and
19 triggers shame.
20

21 66. Denying gender affirming care not only frustrates those treatment goals but
22 exacerbates gender dysphoria and its associated depression and suicidality. Conversely, Bauer et
23 al. found a 62% reduction in risk of suicide ideation with the completion of medical transition.
24 That corresponds to a potential prevention of 240 suicide attempts per 1,000 per year. Studies
25 have also shown that gender confirmation surgery has been linked with a reduction in
26

1 psychological distress and suicidal ideation for transgender patients (Almazan, et al., 2021).

2 Withholding this care results in serious negative health outcomes for transgender patients.

3 67. More broadly, the negative effects of discrimination impact transgender people
4 throughout their lives. A wealth of research establishes that transgender people suffer from
5 discrimination, stigma, and shame from those external forces. The “minority stress model”
6 explains that the negative impact of the stress attached to being stigmatized is socially based. The
7 stress process can be both external—i.e., actual experiences of rejection and discrimination
8 (enacted stigma)—and because of such experiences, internal—i.e., perceived rejection and the
9 expectation of being rejected or discriminated against (felt stigma). A 2015 survey of 28,000
10 transgender and gender nonconforming individuals found that 30% reported being fired,
11 discriminated against, or otherwise experiencing mistreatment in the workplace (James, et al.,
12 2016).

14 68. Experiencing discrimination, including in health care settings, has negative
15 impacts on patients’ mental health and well-being. A 2012 study of transgender adults found fear
16 of discrimination increased the risk of developing hypertension by 100%, owing to the
17 intersectionality of shame and cardiovascular reactivity. Another 2012 study of discrimination
18 and implications for health concluded that “living in states with discriminatory policies ... was
19 associated with a statistically significant increase in the number of psychiatric disorder
20 diagnoses.” And a 2019 study found that experiencing discrimination in health care settings posed
21 a unique risk factor for heightened suicidality among transgender individuals, a population
22 already at heightened risk compared with the general population (Herman, et al., 2019).

24 69. Until recently, it was not fully understood that these experiences of shame and
25 discrimination could have serious and enduring consequences. But it is now known that
26

1 marginalization, stigmatization, and victimization are some of the most powerful predictors of
2 current and future mental health problems, including the development of psychiatric disorders.
3 The social problems that young transgender people face actually create the blueprint for future
4 mental health, life satisfaction, and even physical health. A recent study of 245 gender
5 nonconforming adults found that stress and victimization during childhood and adolescence was
6 associated with a greater risk for post-traumatic stress disorder, depression, life dissatisfaction,
7 anxiety, and suicidality in adulthood (Toomey, et al., 2010). A 2011 Institute of Medicine (IOM)
8 report concurs: “the marginalization of transgender people from society is having a devastating
9 effect on their physical and mental health.” And the American Journal of Public Health recently
10 reported that more than half of transgender women “struggle with depression from the stigma,
11 shame and isolation caused by how others treat them.”
12

13 70. While a growing body of research documents that structural forms of stigma
14 (namely, policies sanctioning discrimination) harm the health of transgender people, a 2010 study
15 was the first to show that structural stigma is associated with all-cause mortality (*i.e.*, deaths from
16 any cause). In other words, stigma—a chronic source of psychological stress—disrupts
17 physiological pathways, increasing disease vulnerability, and leading to premature death.
18

19 71. Adding to the corpus of research in this area is a relatively new approach to the
20 investigation of the relationship between discrimination and health. Neuroscientists have
21 discovered that, in addition to causing serious emotional difficulties and physical harms,
22 discrimination, harassment, and verbal abuse permanently alter the architecture of the brain.
23 Deviations in the myelin sheathing of the corpus callosum and damage to the hippocampus cause
24 cognitive difficulties in individuals who have been routinely subjected to humiliation and
25 ostracism (Nickel, 2018; Ohashi, et al., 2017; Teicher, et al., 2010).
26

IV. ASSESSMENT OF PLAINTIFF C.P.

72. Section IV of this report is designated as CONFIDENTIAL pursuant to the Protective Order in this matter (ECF No. 25).

73. C.P. is a 17-year-old (DOB [REDACTED] 05) who resides in the state of Washington with his parents and two younger siblings. C.P. is a transgender male, having been assigned female at birth.

74. C.P. met all developmental milestones, and his childhood medical history is unremarkable save for a surgery at one year of age to correct Vesicoureteral reflux.

75. I interviewed C.P. remotely, via videoconferencing, on March 19, 2022. C.P. was alert, completely cooperative and maintained eye contact. He sat throughout the interview without fidgeting or restlessness. He engaged with ease, and attention and memory are within normal limits. Speech is normal and well-modulated. Thought processes are logical, goal directed and without distortion. Affect was appropriate to content, and there is no evidence of any mood disorders. Judgement and insight are age appropriate.

76. As a young child, C.P., like most transgender youngsters, felt “different” and confused about the suitability of the assigned sex. C.P. related that he enjoyed and excelled at sports and was most comfortable with male playmates. He consistently wore boys’ clothing and asked to be called by a “boy” name. By age 10, C.P.’s gender identity was so well-established and intractable that he was regarded as male by his peers. Even prior to learning that there is a name for his feelings of incongruity, C.P. essentially transitioned to his affirmed gender. At age 11, he attained a legal name change. Ultimately, when he learned of the condition of gender dysphoria, he experienced enormous relief: “It wasn’t something I was stuck with. I could do something about it.”

1 77. To that end, and with the support of parents and extended family, C.P. was able to
2 obtain the medically necessary care he required, thereby avoiding the negative sequelae of female
3 puberty and attendant menses and unwanted secondary sex characteristics. Dr. Kevin Hatfield
4 monitored C.P.'s pubertal progression, and initiated a GnRH agonist at stage Tanner 2 plus, via a
5 Vantas implant. In due course, intramuscular testosterone, the medically indicated treatment for
6 gender dysphoria, was initiated. This protocol is consistent with the recommendations of The
7 Endocrine Society, the American Medical Association, the American Academy of Pediatricians,
8 and WPATH.
9

10 78. Ultimately, the transmasculine individual requires chest reconstruction. Without
11 this surgery, it is virtually impossible for transgender males to live safely and comfortably. Having
12 female breasts in an otherwise male-appearing body, invokes shame, and can even provoke
13 violence. Without this intervention, transgender males have no alternative except to bind the
14 breasts. Chest binding (compressing breast tissue to give the appearance of a flat chest) is almost
15 universal among transgender men who do not want to appear female. Binding can be extremely
16 uncomfortable, considering that binders are hot and itchy, and can cause serious harm. Over a
17 period of time, binding can affect skin, muscles and movement. Two recent studies, examined the
18 negative effects of binding on data collected from 1,800 transgender males. Of these participants,
19 76-78% experienced skin or tissue related problems: including scarring, swelling, infection; 74-
20 75% reported pain in the chest, shoulders, back or abdomen; 51-52% reported shortness of breath;
21 and 47-49% reported musculoskeletal injuries, including muscle wasting (Peitzmeir et al., 2017;
22 Jarrett et al., 2018). Yet, many transgender men are so intensely uncomfortable with their breasts
23 that they are willing to suffer alarming rampant infection, dyspnea (shortness of breath) and even
24 fractured ribs, to conceal breast tissue (Ettner, 2016).
25
26

1 79. In 2019, C.P. underwent medically indicated chest reconstruction to avoid these
2 hazards.

3 80. At 17 years of age, C.P. is five feet nine inches and weighs 152 pounds. He is
4 indistinguishable from his male peers. C.P. is an excellent student, and works as a lifeguard and
5 swim instructor at a local YMCA. C.P. has never been diagnosed with any mental health issues,
6 and does not use recreational drugs, tobacco, or alcohol. He attends both high school and a
7 technical school in preparation for a career in fire-fighting.

8 81. Individuals like C.P. diagnosed with early-onset gender dysphoria that persists into
9 adolescence, typically suffer the most severe expression of the condition. By analogy, type-one
10 diabetes appears in childhood and differs from type-two diabetes, which typically is a disease
11 arising in adulthood. The treatment of the conditions can differ, with the latter often being less
12 severe and not necessarily requiring insulin. The appropriate, medically necessary treatment that
13 C.P. received, and the treatments he may require in the future, allow him to fulfill his potential and
14 to focus on the normal challenges of life, such as making a living and forming relationships.
15

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EXPERT REPORT OF DR. RANDI C. ETTNER – 25
[Case No. 3:20-cv-06145-RJB]

EXHIBIT A

EXPERT REPORT OF DR. RANDI C. ETTNER, PH.D.

C.P. v. Blue Cross Blue Shield of Illinois, Case No. 3:20-cv-06145-RJB (W.D. Wash.)

RANDI ETTNER, PHD
1214 Lake Street
Evanston, Illinois 60201
847-328-3433

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of
Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association for Transgender Health
(WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee Curriculum Development, WPATH
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial
Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgender Health*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international
appearances)
Internationally syndicated columnist on women's health issues
Private practitioner
Medical staff; Department of Medicine: Weiss Memorial Hospital, Chicago,
IL
Advisory Council, National Center for Gender Spectrum Health
Global Clinical Practice Network; World Health Organization

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

2016-2022	Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery Consultant: Walgreens; Tawani Enterprises Private practitioner/ Supervision
2011	Instructor, Prescott College: Gender-A multidimensional approach
2000	Instructor, Illinois School of Professional Psychology
1995-present	Supervision of clinicians in counseling gender non-conforming clients
1993	Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
1992	Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
1983-1984	Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
1981-1984	Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
1976-1978	Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1975-1977	Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1971	Research Associate, Department of Psychology, Indiana University
1970-1972	Teaching Assistant in Experimental and Introductory Psychology Department of Psychology, Indiana University
1969-1971	Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

INVITED PRESENTATIONS AND HOSPITAL GRAND ROUNDS

Sexual Function: Expectations and outcomes for patients undergoing gender-affirming surgery. Whitney, N., Ettner, R., Schechter, L. Rush University, Department of Plastic and Reconstructive Surgery, Chicago, IL 2022

Care of the Older Transgender Patient, Weiss Memorial Hospital, Chicago, IL, 2021

Working with Medical Experts, The National LGBT Law Association, webinar presentation, 2020

Legal Issues Facing the Transgender Community, Illinois State Bar Association, Chicago, IL, 2020

Providing Gender Affirming Care to Transgender Patients, American Medical Student Association, webinar presentation, 2020

Foundations in Mental Health for Working with Transgender Clients; Advanced Mental Health Issues, Ethical Issues in the Delivery of Care, Center for Supporting Community Development Initiatives, Vietduc University Hospital, Hanoi, Vietnam, 2020

The Transgender Surgical Patient, American Society of Plastic Surgeons, Miami, FL 2019

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018

Expectations of individuals undergoing gender-confirming surgeries Schechter, L., White, T., Ritz, N., Ettner, R. Buenos Aires, 2018

The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery, American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating transference and countertransference issues, WPATH Global Education Initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, IL, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, CA, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Can two wrongs make a right? Expanding models of care beyond the divide, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH Global Education Initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Columbia, MO, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017, Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

Pre-operative evaluation in gender-affirming surgery-American Society of Plastic Surgeons, Boston, MA, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care- Fenway Health Clinic, Boston, 2015

Transgender surgery- Midwestern Association of Plastic Surgeons, Chicago, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, Chicago, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, 2013

Role of the forensic psychologist in transgender care; Care of the aging transgender patient University of California San Francisco, Center for Excellence, 2013

Grand Rounds: Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011

Grand Rounds: Evidence-based care of transgender patients Roosevelt-St. Vincent Hospital, New York, 2011

Grand Rounds: Evidence-based care of transgender patients Columbia Presbyterian Hospital, Columbia University, New York, 2011

Hypertension: Pathophysiology of a secret. WPATH symposium, Atlanta, GA, 2011

Exploring the Clinical Utility of Transsexual Typologies Oslo, Norway, 2009

Children of Transsexuals-International Association of Sex Researchers, Ottawa, Canada, 2005

Children of Transsexuals Chicago School of Professional Psychology, Chicago, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

Gender Identity, Gender Dysphoria and Clinical Issues –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory

University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychonuerioimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984.

Grand Rounds: Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

PUBLICATIONS

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Confessions of a Gender Defender: A Psychologist’s Reflections on Life amongst the Transgender. Chicago Spectrum Press. 1996.

“Post-traumatic Stress Disorder,” *Chicago Daily Law Bulletin*, 1995.

“Compensation for Mental Injury,” *Chicago Daily Law Bulletin*, 1994.

“Workshop Model for the Inclusion and Treatment of the Families of Transsexuals,” Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

“Transsexualism- The Phenotypic Variable,” Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

“The Work of Worrying: Emotional Preparation for Labor,” Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

University of Minnesota, Institute for Sexual and Gender Health; *50 Distinguished Sex and Gender Revolutionaries* award, 2021

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018

The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016

Phi Beta Kappa, 1972

Indiana University Women's Honor Society, 1970-1972

Indiana University Honors Program, 1970-1972

Merit Scholarship Recipient, 1970-1972

Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972

Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

EXHIBIT B

BIBLIOGRAPHY

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